HEALTH LODGE SCOUTMASTER CHECKLIST

On Sundays, *before check-in,* Scoutmasters are responsible for:

1. **Ensuring that each camper's medical form is filled out completely and correctly.**

    a. Is the form either typed or printed legibly in ink?
    b. Is the scout's personal information, (full name, troop number, emergency contact, etc.) complete and accurate?
    c. Is the physical examination component of the form (to be completed by the scout's physician) filled out completely and accurately or is a similar "standard" physical form attached from the doctor's office? Has it been signed by the doctor? (Electronic signatures are acceptable.)
    d. Is the camper allergic to any foods or medications? If so, have they been listed I the appropriate place on the form (with reactions listed in parentheses)?
    Example: "peanuts (anaphylaxis)."
    e. Is the camper taking any medications? If so, are they listed in the correct place on the form? Is the name of the medication, as well as its dosage (i.e., 25 mg), frequency (i.e., twice a day) listed correctly?
    f. Has the camper's parent or guardian signed in the appropriate spot on the form?
    g. Has a copy of (both sides of) the camper's health insurance card been attached to the form?

2. **Ensuring that campers who take medications have their medications with them.**

    a. Is the medication bottled correctly for distribution in camp? (See Health Lodge FAQ's) for details.
    b. Does the information on the bottle match the information on the health form exactly? If there is a discrepancy, is there a new order from the doctor attached to the medical form to clarify the situation?

HEALTH LODGE FACTS

Can a doctor use a pre-printed or computerized physical form instead of the BSA form?
Yes, however it must be attached to a completed BSA form. The BSA form has certain vital information that may not be on the doctor's form (such as emergency contact information, etc.)

Can a doctor sign the physical form electronically? Yes.

My son has an inhaler or an epipen. Can he carry it on him or does he have to leave it at the Health Lodge?
Responsible scouts may carry inhalers and epipens with them during camp after consultation with the nurse during check-in on Sunday. It is strongly recommended that scouts bring two inhalers to camp: one to carry and one to leave in the Health Lodge for emergencies.
NOTE: If a scout carries his epipen or inhaler, he must have it with him at all times.

What about over-the-counter-medication? Can my son carry Advil or Tylenol with him?
No. All medications, including those available over-the-counter, must be dispensed by the Health Lodge. Exceptions to this rule must be approved by the Health Officer. (See above.)

My son has an occasional headache or occasional allergies. Should I send Tylenol, Advil or Benadryl with him to camp?
No. The camp has a supply of these medications for scouts who need them occasionally. However, if your son requires a medication every day, please send it to camp with him even if it is over-the-counter.

Do medications need to be in certain bottles?
Yes. Prescription medications must be in the original bottle given to you by the pharmacy.
Over-the-counter medications must be unopened to be distributed at camp.

Can I use a seven-day planner or some other method for sending my son's medication?
No. Although systems like these might help you keep your son's medication organized at home, BSA and the Commonwealth of Massachusetts mandate that medications be bottled properly to be dispensed at camp. (See above.)

Do over-the-counter medications really need to be in an unopened bottle? Yes

Are there exceptions to this rule? No.

I am an adult leader. Do I need a medical form?
Yes. If you are staying for more than three (3) nights, your BSA form should be filled out completely, including a physical from a doctor within the last year. If you are staying for less than three (3) nights, you must complete a BSA form, although a physical is not necessary.

What are the most common reasons a Scout comes to the Health Office?
Dehydration and ticks. Scouts should be sure to drink plenty of water and be vigilant to check for tics. Frequent showering and hand washing help stop the spread of bacteria and promote good hygiene.

My scout has medication. When should he take it?
Medication is dispensed from:

7:00 – 7:30 am; 8:30 – 9:00 am; 12:45 – 1:15 pm; 5:00 – 5:30 pm; 8:30 – 9:30 pm

It is best for scouts to take morning medications from 7:00 – 7:30 am to ensure that they make it to 9:00 am merit badge classes on time.

What happens if my scout misses his medication?
All medications are prescribed for a reason. Those that are prescribed to be taken daily (or multiple times during a day) are necessary for the patient's well-being.
Therefore, the following procedures are in place when a scout misses his medication:

First Time –	The camper's Scoutmaster is informed
Second Time –	The camper's parent is called
Third Time –	The camper is sent home.

Scouts who repeatedly miss their medications present a significant medical danger to themselves. These boys cannot remain in camp for their own safety.

My son is taking a prescription medication. The dosage has been modified since his physical. What does the camp need to ensure that he receive his medication correctly?
Your son's medical form and prescription bottle (dosage, frequency, etc.) must match exactly. If the two forms do not match, we need a modified order from the doctor to dispense his medication.

Can I fax or e-mail documents to Camp?
Yes. The fax number is 508-224-9444. Documents may also be emailed: Wlems48@hotmail.com

What are the Health Lodge's hours?
7:00 am to 10:00 pm for all health concerns. 10:00 pm to 7:00 am for any genuine emergency.

How can I make check-in go more quickly?
The best way to make check-in go faster is to comply completely with all camp health regulations. Delays occur when people do not follow these instructions. This slows everything down.

What if I have other questions?
Your Scoutmaster should be able to answer most questions, but do not hesitate to call the camp at 508-224-2010 at any time. Answering a question before camp begins might take only seconds, but not knowing the correct answer could potentially cost parents, Scoutmasters, staff and campers hours of time.

What happens to my son's medication when camp is over?
All medical forms and medications are returned to your son's Scoutmaster on Saturday morning. He or she will ensure they are given back to you.

MEDICAL INFORMATION

Camp Squanto operates in compliance with the Boy Scouts of America Plans and Procedures for Operating a Resident Boy Scout Camp, Commonwealth of Massachusetts Safety Standards for Recreational Camps for Children (105CMR 430.000 through 105 CMR 430.830), and Old Colony Council Camp Policies.

Camp Squanto has developed a comprehensive and detailed Health and Safety Guide, which contains policies covering emergencies, safety issues, Health Lodge operations, medical treatment, discipline, and background checks.

A copy of this complete guide is available for your review at the Old Colony Council office at 2438 Washington St., Canton MA (781) 828-8360, or during summer camp operation at Camp Squanto Director's Office and it's Health Lodge.

MEDICAL FORM

The following is the Policy at Camp Squanto regarding Medical Forms:

- All Scouts and Leaders, under age 40, attending camp MUST have a medical exam performed by a physician within 24 months of your camp arrival date, however, your Medical form must be revised each 12 months. Therefore, your medical form must be signed by a physician within the past 12 months but you need only to have had a physical exam within the last 24 months.

- All leaders over age 40 attending camp MUST have a medical exam performed by a physician within 12 months of your camp arrival date.

- All completed medical forms are presented to the Health Lodge upon arrival. **SCOUTS AND ADULT LEADERS WILL NOT BE PERMITTED TO REMAIN IN CAMP WITHOUT A PROPERLY COMPLETED HEALTH RECORD. CURRENT IMMUNIZATION DATES ARE REQUIRED BY STATE LAW.** Check marks or words "Up to date" are not acceptable. **ALL MEDICATIONS MUST COME IN ITS ORIGINAL CONTAINERS. ALL MEDICAL FORMS MUST BE SIGNED BY A PHYSICIAN, APPLICANT AND A PARENT/GUARDIAN IF UNDER 18, WITHIN THE LAST TWELVE MONTHS UNLESS STAYING LESS THAN 72 HOURS.**

- A photocopy of the medical insurance card is attached to the medical form.

Again, if you are under 40 you need only to have had a physical within the past two years, but the form still needs to be signed by a physician within the last year.

TREATMENT OF MILDLY ILL CAMPERS

Mildly ill campers will be treated using good nursing judgment following procedures approved by our Health Care Consultant. Administration of medication will be done by our Camp Health Supervisor following the directions provided by the prescription label or by a written Doctor's order and for non-prescription products by the product label or by a Doctor's note. NO EXCEPTIONS. Emergency health care will be provided on site by trained first aid staff, followed up by our Health Lodge staff and transport to Jordan Hospital if deemed necessary.

Annual Health and Medical Record
Registro Médico y de Salud Anual
Part A/Parte A

High-adventure base participants:
Participantes en la base de aventura extrema:
Expedition/crew No.
Expedición/grupo no.: _____
or staff position
o puesto fijo: _____

GENERAL INFORMATION/INFORMACIÓN GENERAL

Name _____ Date of birth _____ Age _____ ◯ Male ◯ Female
Nombre Fecha de nacimiento (MM/DD/Year) - (MM/DD/Año) Edad Masculino Femenino

Address _____ Grade completed (youth only) _____
Domicilio Grado escolar completado (sólo niños)

City _____ State _____ Zip _____ Phone No. _____
Ciudad Estado Código postal No. telefónico

Unit leader _____ Council name/No. _____ Unit No. _____
Líder de la unidad Nombre y no. del concilio No. de unidad

Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
No. de Seguro Social (opcional; puede ser solicitado por las instalaciones médicas para brindar tratamiento) Preferencia religiosa

Health/accident insurance company _____ Policy No. _____
Compañía de seguro médico/accidental No. de póliza

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.
ANEXAR UNA FOTOCOPIA DE AMBOS LADOS DE LA TARJETA DEL SEGURO. SI USTED NO TIENE SEGURO MÉDICO, ESCRIBA "NINGUNO."

In case of emergency, notify/En caso de emergencia, notificar a:

Name _____ Relationship _____
Nombre Parentesco

Address _____
Domicilio

Home phone _____ Business phone _____ Mobile phone _____
Teléfono de casa Teléfono de oficina Teléfono móvil

Alternate contact name _____ Alternate's phone _____
Nombre de contacto alterno Teléfono del contacto alterno

HEALTH HISTORY/HISTORIAL MÉDICO

Do you currently have, or have you ever been treated for any of the following?
¿Tiene actualmente, o ha tenido alguna vez los siguientes?

Please fill in the bubbles as indicated below:
Por favor rellene los círculos tal como se indica a continuación:
Incorrect: ✓ ✗ ◒ Correct: ●
Incorrecto Correcto

Yes/Sí	No/No	Condition/Padecimiento	Explain/Explique
◯	◯	**Asthma** Asma — **Last attack:** (MM/YY) Último ataque: (MM/AA) ☐☐/☐☐	
◯	◯	**Diabetes** Diabetes — **Last HbA1c:** (Percentage) Última HbA1c: (Porcentaje) ☐☐.☐ %	
◯	◯	**Hypertension (high blood pressure)** Hipertensión (presión alta)	
◯	◯	**Heart disease/heart attack/chest pain/heart murmur** Enfermedad del corazón/infarto/dolores de pecho/soplo cardíaco	
◯	◯	**Stroke/TIA** Apoplejía/Accidente isquémico transitorio	
◯	◯	**Lung/respiratory disease** Enfermedades pulmonares/respiratorias	
◯	◯	**Ear/sinus problems** Problemas del oído/senos paranasales	
◯	◯	**Muscular/skeletal condition** Condiciones musculares/óseas	
◯	◯	**Menstrual problems (women only)** Problemas menstruales (sólo mujeres)	
◯	◯	**Psychiatric/psychological and emotional difficulties** Dificultades psiquiátricas/psicológicas y emocionales	
◯	◯	**Behavioral/neurological disorders** Trastornos de conducta/neurológicos	
◯	◯	**Bleeding disorders** Enfermedades hemorrágicas	
◯	◯	**Fainting spells** Desmayos	
◯	◯	**Thyroid disease** Enfermedades de la tiroides	
◯	◯	**Kidney disease** Enfermedades del riñón	
◯	◯	**Sickle cell disease** Anemia falciforme	
◯	◯	**Seizures** Convulsiones — **Last seizure:** (MM/YY) Última convulsión: (MM/AA) ☐☐/☐☐	
◯	◯	**Sleep disorders (e.g., sleep apnea)** Trastornos del sueño (por ejemplo, síndrome de apnea-hipopnea durante el sueño)	Use CPAP: Usa CPAP ◯ Yes Sí ◯ No No
◯	◯	**Abdominal/digestive problems** Problemas abdominales/digestivos	
◯	◯	**Surgery** Cirugía — **Last surgery:** (MM/YY) Última cirugía: (MM/AA) ☐☐/☐☐	
◯	◯	**Serious injury** Lesión grave	
◯	◯	**Excessive fatigue or shortness of breath with exercise** Fatiga en exceso o dificultad para respirar al hacer ejercicio	
◯	◯	**Other** Otro	

Emergency contact No.: Teléfono en caso de emergencia
Allergies: Alergias
DOB: Fecha de nacimiento
Full name: Nombre completo
Part A Parte A

PART A (*continued on next page*)

HEALTH HISTORY/HISTORIAL MÉDICO

Are you allergic to or do you have any adverse reaction to any of the following?
¿Es alérgico a, o le causa alguna reacción adversa cualquiera de los siguientes?

Please fill in the bubbles as indicated:
Por favor rellene los círculos tal como se indica:

Incorrect: ✓ ✗ ◒ Incorrecto

Correct: ● Correcto

Yes/Sí	No/No	Allergies or Reaction to Alergias o Reacciones a	Explain Explique
○	○	**Medication** Medicamentos	
○	○	**Food, plants, or insect bites** Alimentos, plantas o picaduras de insectos	

The following immunizations are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).

BSA recomienda las siguientes vacunas. **La vacuna contra el Tétanos es obligatoria y debe haberla recibido en los últimos 10 años.** Por cada punto, indique si ha sido vacunado, la fecha en que la recibió (MM/AA), si ha padecido la enfermedad, y la fecha (MM/AA).

Immunized? ¿Vacunado?		Immunizations Vacunas	Date (MM/YY) Fecha (MM/AA)	Had Disease? ¿La ha padecido?		Date (MM/YY) Fecha (MM/AA)
Yes/Sí	No/No			Yes/Sí	No/No	
○	○	**Tetanus** Tétano	☐☐/☐☐	○	○	
○	○	**Pertussis** Tos ferina		○	○	
○	○	**Diphtheria** Difteria		○	○	
○	○	**Measles** Sarampión		○	○	
○	○	**Mumps** Paperas		○	○	
○	○	**Rubella** Rubéola		○	○	
○	○	**Polio** Polio		○	○	
○	○	**Chicken pox** Varicela		○	○	
○	○	**Hepatitis A** Hepatitis A		○	○	
○	○	**Hepatitis B** Hepatitis B		○	○	
○	○	**Meningitis** Meningitis		○	○	
○	○	**Influenza** Influenza		○	○	
○	○	**Other (i.e., HIB)** Otra (por ejemplo, HIB)		○	○	
○		**Exemption to immunizations claimed (form required).** Exención de vacunas solicitada (formulario obligatorio).				

MEDICATIONS List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

○ No medications
Sin medicamentos

○ Additional medications (sheet attached)
Medicamentos adicionales (hoja anexa)

MEDICAMENTOS Enumere todos los medicamentos que usa en la actualidad. (Si requiere espacio adicional, favor de sacar una fotocopia de esta parte del formulario.) Se debe incluir información sobre inhaladores y EpiPen, incluso si son sólo para uso ocasional o en caso de emergencia.

Medication Medicamento _____ Strength / Dosis _____ Frequency / Frecuencia _____ Approximate date started Fecha aproximada de inicio _____ Reason for medication Razón del medicamento _____	Medication Medicamento _____ Strength / Dosis _____ Frequency / Frecuencia _____ Approximate date started Fecha aproximada de inicio _____ Reason for medication Razón del medicamento _____	Medication Medicamento _____ Strength / Dosis _____ Frequency / Frecuencia _____ Approximate date started Fecha aproximada de inicio _____ Reason for medication Razón del medicamento _____
Medication Medicamento _____ Strength / Dosis _____ Frequency / Frecuencia _____ Approximate date started Fecha aproximada de inicio _____ Reason for medication Razón del medicamento _____	Medication Medicamento _____ Strength / Dosis _____ Frequency / Frecuencia _____ Approximate date started Fecha aproximada de inicio _____ Reason for medication Razón del medicamento _____	Medication Medicamento _____ Strength / Dosis _____ Frequency / Frecuencia _____ Approximate date started Fecha aproximada de inicio _____ Reason for medication Razón del medicamento _____

Administration of the above medications is approved by (if required by your state): _____ / _____

La administración de los medicamentos arriba mencionados está aprobada por (si lo requiere su estado) — Parent/guardian signature / Firma del padre o tutor — and/or / y/o — MD/DO, NP, or PA signature / Firma del Dr., Enfermera profesional, Asistente médico

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Asegurarse de traer los medicamentos en cantidades suficientes y en los envases originales. Asegurarse de que NO ESTÉN CADUCADOS, incluyendo inhaladores y EpiPens. NO DEBE DEJAR DE tomar cualquier medicamento de mantenimiento a menos que se lo indique su médico.

DOB: _____ Fecha de nacimiento

Full name: _____ Nombre completo

Part A Parte A

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High-adventure base participants:
Participantes en la base de aventura extrema:
Expedition/crew No./Expedición/grupo no.: _____
or staff position/o puesto fijo: _____

Part B/Parte B

INFORMED CONSENT AND RELEASE AGREEMENT

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

NOTIFICACIÓN DE CONSENTIMIENTO Y EXONERACIÓN DE RESPONSABILIDAD

Entiendo que la participación en actividades Scouting implica un cierto grado de riesgo y que pueden ser física, mental y emocionalmente agotadoras. Asimismo, entiendo que la participación en dichas actividades es completamente voluntaria y requiere que los participantes se acaten a las reglas y estándares de conducta pertinentes.

En caso de que yo, o mi hijo, nos veamos involucrados en un caso de emergencia, entiendo que se hará todo lo posible para contactar al individuo mencionado como persona a contactar en caso de emergencia. En caso de que dicha persona no pueda ser localizada, por este medio otorgo permiso al proveedor de servicios médicos seleccionado por el líder adulto a cargo para asegurar que se proporcione el tratamiento adecuado, incluyendo hospitalización, anestesia, cirugía o inyecciones de medicamentos para mí o mi hijo. Los proveedores médicos están autorizados a compartir información médica protegida con el adulto a cargo, el personal médico del campamento, la administración del campamento, o cualquier médico o proveedor de servicios médicos involucrado en la administración de atención médica al participante. La Información médica protegida/Información médica confidencial (PHI/CHI, por sus siglas en inglés) bajo los Estándares de privacidad de información médica individualmente identificable, 45 C.F.R. §§160.103, 164.501, etc., y siguientes como se enmiendan de vez en cuando, incluye resultados de reconocimientos médicos, resultados de pruebas y tratamiento proporcionado para propósitos de evaluación médica del participante, seguimiento y comunicación con los padres o tutor del participante, y determinación de la habilidad del participante de continuar con las actividades del programa.

He considerado cuidadosamente el riesgo implicado y he dado el consentimiento para mí mismo o mi hijo de participar en dichas actividades. Apruebo que se comparta la información contenida en este formulario con los voluntarios y profesionales de BSA que necesiten tener conocimiento de condiciones médicas que puedan requerir consideración especial para la realización de actividades Scouting de manera segura.

Eximo a Boy Scouts of America, al concilio local, a los coordinadores de la actividad y a todos los empleados, voluntarios, grupos involucrados u otras organizaciones asociadas con la actividad, de cualquier y toda reclamación o responsabilidad que surja a raíz de esta participación.

◯ Without restrictions./Sin restricciones.

◯ With special considerations or restrictions (list)/Con condiciones especiales o restricciones (lista):

_____

_____

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

◯ Yes/Sí

◯ No/No

Por este conducto asigno y otorgo al concilio local y a Boy Scouts of America el derecho y permiso para usar y publicar las fotografías/películas/ videocintas/representaciones electrónicas y grabaciones de sonido de mí o mi hijo realizadas en todas las actividades Scouting, y por este medio exonero a Boy Scouts of America, al concilio local, a los coordinadores de la actividad y a todos los empleados, voluntarios, grupos involucrados u otras organizaciones asociadas con la actividad, de cualquier y toda responsabilidad por dicho uso y publicación.

Por este conducto autorizo la reproducción, venta, derechos reservados, exhibición, transmisión, almacenamiento electrónico y distribución de dichas fotografías/películas/ videocintas/representaciones electrónicas y grabaciones de sonido sin limitación a discreción de Boy Scouts of America, y específicamente renuncio a cualquier derecho de compensación alguna que pueda tener por cualquiera de lo anterior.

DOB: _____ Fecha de nacimiento

Full name: _____ Nombre completo

Part B Parte B

PART B (*continued on next page*)

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

You must designate at least one adult. Please include a telephone number.

ADULTOS AUTORIZADOS PARA TRANSPORTAR AL NIÑO HACIA Y DESDE LOS EVENTOS:

Debe designar por lo menos a un adulto. Por favor incluya un número telefónico.

1. Name/Nombre _____ Telephone/Teléfono _____

2. Name/Nombre _____ Telephone/Teléfono _____

3. Name/Nombre _____ Telephone/Teléfono _____

Adults NOT authorized to take youth to and from events/Adultos NO autorizados para transportar al niño hacia y desde los eventos:

1. Name/Nombre _____ Telephone/Teléfono _____

2. Name/Nombre _____ Telephone/Teléfono _____

3. Name/Nombre _____ Telephone/Teléfono _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve: I have also read and understand the risk advisories explained in Part D, *including height and weight requirements and restrictions,* and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Entiendo que, si cualquier información que he/hemos proporcionado es errónea, puede limitar o eliminar la oportunidad de participación en cualquier evento o actividad.

Si participo en Philmont, el Centro de Capacitación Philmont, Northern Tier, la Base Marina de la Florida o Summit Bechtel Reserve: También he leído y entiendo las advertencias de riesgo explicadas en la Parte D, *incluyendo los requisitos y restricciones de estatura y peso*, y entiendo que al participante no se le permitirá intervenir en programas de aventura extrema si dichos requisitos no se cumplen. El participante tiene permiso de intervenir en todas las actividades de aventura extrema descritas, excepto aquellas específicamente señaladas por mí o el proveedor de servicios médicos. Si el participante es menor de 18 años, se requiere la firma de el padre/madre o tutor.

Participant's name/Nombre del participante _____

Participant's signature/Firma del participante _____ Date/Fecha _____

Parent/guardian's signature/Firma del padre o tutor _____ Date/Fecha _____
(if participant is under the age of 18/si el participante es menor de 18 años)

Second parent/guardian signature/Firma del otro padre o tutor _____ Date/Fecha _____
(if required; for example, CA/si se requiere; por ejemplo en CA)

This Annual Health and Medical Record is valid for 12 calendar months.
Este Registro Médico y de Salud Anual tiene vigencia por 12 meses calendario.

Part B Parte B

Full name: Nombre completo _____

DOB: Fecha de nacimiento _____

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Part C/Parte C
Pre-participation Physical
Examen físico previo a la participación

High-adventure base participants:
Participantes en la base de aventura extrema:
Expedition/crew No.
Expedición/grupo no.:_____
or staff position
o puesto fijo: _____

TO THE EXAMINING HEALTH CARE PROVIDER
(Certified and licensed physicians [MD, DO], nurse practitioners, and physician assistants)

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience as described in Part D. For individuals who will be attending a high-adventure program, either unit-based or at one of the national high-adventure bases, please refer to Part D for additional information.

PARA EL PROVEEDOR DE SERVICIOS DE SALUD QUE REALICE EL RECONOCIMIENTO (Médicos certificados y licenciados, enfermeras profesionales y asistentes médicos)

Se les está solicitando que certifiquen que este individuo no tiene contraindicación para participar en una experiencia Scouting tal como se describe en la Parte D. Para individuos que estarán participando en un programa de aventura extrema, ya sea en la unidad o en una de las bases nacionales de aventura extrema, por favor consulte la Parte D para información adicional.

Height (inches) / Estatura (pulgadas) ☐☐.☐
Weight (pounds) / Peso (libras) ☐☐☐.☐
Maximum weight for height / Máximo peso para la estatura ☐☐☐
Meets height/weight limits / Cumple con los límites de estatura/peso ◯ Yes/Sí ◯ No/No

Blood pressure / Presión arterial ☐☐☐/☐☐☐
Pulse / Pulso ☐☐☐
Percent body fat (optional) / Porcentaje de grasa corporal (opcional) ☐☐☐.☐

If you exceed the maximum weight for height as explained on the next page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisers of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a hydrostatic weighing or DXA test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

Si usted excede el peso máximo para su estatura tal como se explica en la siguiente página y su actividad de aventura extrema planeada le llevará a más de 30 minutos de distancia de una vía con acceso para un vehículo de emergencia, usted **no podrá** participar. A juicio de los consejeros médicos del evento o campamento, la participación de un individuo que exceda el peso máximo para su estatura puede permitirse si el porcentaje de grasa corporal medida por el proveedor de servicios de salud determina que es 20 por ciento o menos para una mujer o 15 por ciento o menos para un hombre. (Philmont requiere que se use una prueba de peso hidrostático o de densitometría ósea para determinarlo). Por favor llame al líder del evento o del campamento si tiene preguntas. El cumplimiento de los lineamientos de estatura y peso se recomienda encarecidamente para todos los demás eventos.

Examiner: Please fill in the information.
Examinador: Favor de completar la información.

Please fill in the bubbles as indicated: / Por favor rellene los círculos tal como se indica: Incorrect: / Incorrecto ✓ ✗ ◒ Correct: / Correcto ●

	Normal / Normal	Abnormal / Anormal	Explain Any Abnormalities / Explique cualquier anomalía
Eyes Ojos	◯	◯	
Ears Oídos	◯	◯	
Nose Nariz	◯	◯	
Throat Garganta	◯	◯	
Lungs Pulmones	◯	◯	
Neurological Neurológico	◯	◯	
Heart Corazón	◯	◯	
Abdomen Abdomen	◯	◯	
Genitalia/hernia Genitales/hernia	◯	◯	
Skin Piel	◯	◯	
Emotional adjustment Ajuste emocional	◯	◯	

	Normal / Normal	Abnormal / Anormal	Explain Any Abnormalities / Explique cualquier anomalía
Knees (both) Rodillas (ambas)	◯	◯	
Ankles (both) Tobillos (ambos)	◯	◯	
Spine Espina	◯	◯	

Other / Otro	Yes / Sí	No / No	Explain / Explique
Personal or family history of heart disease Historial personal o familiar de enfermedad cardíaca	◯	◯	
Medical equipment (i.e., CPAP, oxygen) Equipo médico (por ejemplo, CPAP, oxígeno)	◯	◯	
Contacts Lentes de contacto	◯	◯	
Dentures Dentaduras	◯	◯	
Braces Tratamientos de ortodoncia	◯	◯	

Tuberculosis (TB) skin test (if required by your state for BSA camp staff): ◯ Negative/Negativo ◯ Positive/Positivo
Prueba de Tuberculosis (TB) (si lo requiere su estado para personal del campamento BSA)

Allergies/Alergias: ◯ No/No ◯ Yes/Sí (explain to what agent, type of reaction, treatment/explique a qué agente, tipo de reacción, tratamiento):

Medical restrictions to participate/Restricciones médicas para participar: ◯ No/No ◯ Yes/Sí (explain/explique):

DOB: _____ Fecha de nacimiento

Part C Full name: _____ Parte C Nombre completo

PART C (*continued on next page*)

Part C Parte C

Full name: Nombre completo

DOB: Fecha de nacimiento

EXAMINER'S CERTIFICATION
CERTIFICACIÓN DEL EXAMINADOR

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions above):

Certifico que he revisado el historial médico, examinado a esta persona y no encuentro contradicciones para su participación en una experiencia Scouting. Este participante (con las restricciones descritas anteriormente):

Please fill in the bubbles as indicated:
Por favor rellene los círculos tal como se indica:
Incorrect: Incorrecto ✓ ✗ ◒ Correct: Correcto ●

True Cierto	False Falso	
○	○	**Meets height/weight requirements** Cumple con los requisitos de estatura/peso
○	○	**Does not have uncontrolled heart disease, asthma, or hypertension** No tiene cardiopatía, asma o hipertensión incontrolados
○	○	**Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician** No ha tenido una lesión ortopédica, problemas musculoesqueléticos o cirugía ortopédica en los últimos seis meses o posee una carta de autorización por parte de su cirujano ortopédico o médico
○	○	**Has no uncontrolled psychiatric disorders** No tiene trastornos psiquiátricos incontrolados
○	○	**Has had no seizures in the last year** No ha tenido convulsiones en el último año
○	○	**Does not have poorly controlled diabetes** No tiene diabetes mal controlada
○	○	**If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures** Si tiene menos de 18 años de edad y piensa realizar buceo, no tiene diabetes, asma o convulsiones
○	○	**I have reviewed Part D for high-adventure activities.** He revisado la Parte D para actividades de aventura extrema.

Provider printed name
Nombre del proveedor _____

Address
Domicilio _____

City, state, zip
Ciudad, estado, código postal _____

Office phone
Teléfono del consultorio _____

Date
Fecha _____

Examiner signature in the box below.
Firma del examinador en el recuadro de abajo.

Height (inches) Estatura (pulgadas)	Recommended Weight (lbs) Peso recomendado (libras)	Allowable Exception Excepción permitida	Maximum Acceptance Aceptación máxima
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

Esta tabla está basada en los Lineamientos dietéticos para estadounidenses del Departamento de Agricultura de los EE.UU. y del Departamento de Salud y Servicios Humanos.

DO NOT WRITE IN THIS BOX
NO ESCRIBA EN ESTE RECUADRO

REVIEW FOR CAMP OR SPECIAL ACTIVITY/REVISIÓN PARA CAMPAMENTO O ACTIVIDAD ESPECIAL

Reviewed by
Revisado por _____

Date
Fecha _____

Further approval required ○ Yes Sí ○ No No
Se requiere aprobación adicional

Reason
Razón _____

Approved by
Aprobado por _____

Date
Fecha _____

Click here for more information regarding high-adventure outings or go to www.scouting.org/filestore/HealthSafety/pdf/part_d.pdf.
Haga clic aquí para obtener más información sobre las excursiones de aventura extrema o visite www.scouting.org/filestore/HealthSafety/pdf/part_d.pdf.

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